Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3522AGC 04/08/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4618 SPRUCE OAK** SPRUCE OAK RESIDENTIAL CARE FACILITY NORTH LAS VEGAS, NV 89031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 04/08/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 6 Residential Facility for Group beds for elderly and disabled persons. Category II residents. The census at the time of the survey was 1. One resident file was reviewed and four employee files were reviewed. There were no complaints investigated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified: Y 051 Y 051 449.194(2) Administrator's SS=C Responsibilities-Designation NAC 449.194 The administrator of a residential

facility shall:

2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the

facility have access if the confidential information

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

is maintained by the administrator. The

		(X1) PROVIDER/SUPPLIER/O		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS3522AGC		B. WING		04/0	8/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
SPRUCE (OAK RESIDENTIAL CAR	E FACILITY	4618 SPRU NORTH LA	CE OAK S VEGAS, NV	89031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 051	Continued From page	 e 1		Y 051			
	administrator or an ento be in charge of the subsection shall be p times. The name of the facility pursuant to	mployee who is designate facility pursuant to this present at the facility at the employee in charge to this subsection must lace within the facility during the subsection of the facility during the subsection in the facility during the subsection of the subsection in the facility during the subsection in the facility during the subsection in the facility during the subsection in the sub	all of be				
	This Regulation is not met as evidenced by: Based on observation, interview, and record review on 04/08/09, the administrator failed to designate one or more employees to be in charge of the facility.		to				
	Severity: 1 Scope:	3					
Y 053 SS=F	449.194(4) Administr Responsibilities-Com			Y 053			
		a residential facility sha cords of the facility are te.	II:				
	Based on observation review on 04/08/09, t	ot met as evidenced by: n, interview, and record the administrator failed the facility complete and	to				
	Severity: 2 Scope:	3					

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

NVS3522AGC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4618 SPRUCE OAK

SPRUCE	OAK RESIDENTIAL CARE FACILITY	4618 SPRUCE OAK NORTH LAS VEGAS, NV 89031					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 067	Continued From page 2		Y 067				
Y 067 SS=C	449.196(1)(c) Qualifications of Caregiver- Reregulation	ead	Y 067				
	NAC 449.196 1. A caregiver of a residential facility must: (c) Understand the provisions of NAC 449.156 to 449.2766, inclusive, and sign a statement that he has read those provisions.						
	This Regulation is not met as evidenced by: Based on record review and interview on 04/08/09, the facility failed to ensure that 4 c caregivers read the provisions of NAC 449.1 449.2766 and signed a statement that he/sh read those regulations (Employee #1, #2, #3 #4).	of 4 56 to e has					
	Severity: 1 Scope: 3						
Y 072 SS=F	449.196(3) Qualications of Caregiver-Med re-training		Y 072				
	NAC 449.196 3. If a caregiver assists a resident of a resider facility in the administration of any medication including, without limitation, an over-the-cour medication or dietary supplement, the caregimust: (a) Receive, in addition to the training require pursuant to NRS 449.037, at least 3 hours of training in the management of medication. To caregiver must receive the training at least east greater and provide the residential facility with the caregiver must receive the training at least east greater and provide the residential facility with the caregiver must receive the training at least east greater and provide the residential facility with the caregiver must receive the training at least greater and provide the residential facility with the caregiver must receive the training at least greater and provide the residential facility with the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive the training at least greater and the caregiver must receive	on, nter iver ed if ihe every					

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVS3522AGC 04/08/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRUCE (DAK RESIDENTIAL CARE FACILITY	4618 SPRUCE OAK NORTH LAS VEGAS, NV 89031					
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Y 072	Continued From page 3 satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examinat relating to the management of medication approved by the Bureau.	aining	7 072				
	This Regulation is not met as evidenced by Based on record review and interview on 04/08/09, the facility failed to ensure that 3 caregivers had completed the required three medication management refresher training ethree years (Employee #2, #3 and #4).	of 4 e hour					
Y 088 SS=C	Severity: 2 Scope: 3 4493199(4) Staffing Schedule	Y	′ 088				
33-0	NAC 449.199 4. The administrator of a residential facility s maintain monthly a written schedule that inc the number and type of members of the staff the facility assigned for each shift. The schemust be amended if any changes are made schedule. The schedule must be retained for least 6 months after the schedule expires.	ludes f of edule to the					
	This Regulation is not met as evidenced by Based on record review and interview on 04/08/09, the administrator failed to maintair retain (for at least six months) a monthly sta schedule.	n and					

	OF DEFICIENCIES F CORRECTION	I (XI) I NOVIDEIVOOI I EIEIVOEIX I (XZ) MULTIFLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED 04/08/2009		
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDF	RESS, CITY, STA	TE, ZIP CODE	, , , ,	
SPRUCE (DAK RESIDENTIAL CAI	RE FACILITY	4618 SPRU NORTH LAS	CE OAK S VEGAS, NV	89031		
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Y 088	Continued From pag	je 4		Y 088			
	Severity: 1 Scope:	3					
Y 103 SS=F				Y 103			
	a separate personne member of the staff	ise provided in subsection is provided in subsection is file must be kept for export a facility and must indicates required pursuant C for the employee.	ach clude:				
	Based on record rev 04/08/09, the facility caregivers complied regarding tuberculos	not met as evidenced by riew and interview on failed to ensure 4 of 4 with NAC 441A.375 sis testing (Employee #1 protection of all residents	l, # 2,				
	Severity: 2 Scope:	3					
Y 104 SS=C	449.200(1)(e) Perso	nnel File - References		Y 104			
	a separate personne member of the staff (e) Evidence that the	ise provided in subsection is provided in subsection of a facility and must income references supplied by the residential factorial fact	ach clude: / the				
	This Regulation is n	ot met as evidenced by	:				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS3522AGC		B. WING		04/0	8/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
SPRUCE (OAK RESIDENTIAL CAR	E FACILITY	4618 SPRU NORTH LAS	CE OAK S VEGAS, NV	89031		
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Y 104	Continued From page	e 5		Y 104			
		ew and interview on ailed to investigate the mployees (Employee #					
	Severity: 1 Scope:	3					
Y 105 SS=F	449.200(1)(f) Personi	nel File - Background C	Check	Y 105			
	a separate personnel member of the staff o	se provided in subsection file must be kept for early and must including with NRS 449.17	ach clude:				
	Based on record review 04/08/09, the facility f	failed to ensure 4 of 4 pround check requirement					
	Severity: 2 Scope: 3	3					
Y 206 SS=C	449.211(4)(a) Automa Inspections	atic Sprinklers-Quarterl	у	Y 206			
	NAC 449.211 4. An automatic sprin has been installed in facility must be inspectation (a) Not less than once quarter by a person with manner in which the second control of the	a residential cted: e each calendar who understands the					

PRINTED: 05/01/2009

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVS3522AGC 04/08/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4618 SPRUCE OAK SDDUCE OAK DESIDENTIAL CADE EACH ITV

SPRUCE	SPRUCE OAK RESIDENTIAL CARE FACILITY		NORTH LAS VEGAS, NV 89031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 206	Continued From page 6 and the manner in which it should be maintained.	Y2	206			
	This Regulation is not met as evidenced by Based on record review and interview on 04/08/09, the facility failed to have its autom sprinkler system inspected for 1 of the last 4 quarters (October 2008 to March 2009).	atic				
	Severity: 1 Scope: 3					
Y 434 SS=F	449.229(3) Emergency Drills	Y 4	134			
	NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a writ record of each drill must be kept on file at th facility for not less than 12 months after the	e				
	This Regulation is not met as evidenced by Based on record review and interview on 04/08/09, the facility failed to ensure that mo evacuation drills were conducted on an irreg schedule for the past 12 of 12 months (April to April 2009).	onthly gular				
	This was a repeat deficiency from the 05/31. State Licensure survey.	/08				
	Severity: 2 Scope: 3					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPLE	
			.52.1.	A. BUILDING			
		NVS3522AGC		B. WING		04/	/08/2009
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
SPRUCE	OAK RESIDENTIAL CAR	RE FACILITY	4618 SPRU NORTH LAS	CE OAK S VEGAS, NV	89031		
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Y 444	Continued From pag	e 7		Y 444			
Y 444 SS=F	NAC 449.229		propor	Y 444			
	operating conditions		pe				
	Based on record revi 04/08/09, the facility	failed to ensure smoked 12 of the past 12 mo	e				
	This was a repeat de State Licensure surv	eficiency from the 05/3 rey.	1/08				
	Severity: 2 Scope:	3					
Y 532 SS=C	449.260(1)(g)(1)(2) A	Activities for Residents		Y 532			
	facility shall: (g) Post, in a commo calendar of activities residents of the majo the facility. The cale (1) Prepared at	least a month in advar n file at the facility for r	otifies cur in nce.				
	Based on observatio	ot met as evidenced b n, interview, and recor the facility failed to pos	d				

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS3522AGC		B. WING		04/0	8/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	-	
SPRUCE (OAK RESIDENTIAL CAR	E FACILITY	4618 SPRU NORTH LAS	CE OAK S VEGAS, NV	89031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Y 532	Continued From page	e 8		Y 532			
	a file of 6 months wor	ctivity calendar and ma th of previous activity nonths (October 2008 to					
	Severity: 1 Scope:	3					
Y 859 SS=F	449.274(5) Periodic F resident	Physical examination of	·a	Y 859			
	resident, the facility s general physical exar his physician. The re	<u>-</u>	of a ∶by				
	Based on record review 04/08/09, the facility f	ot met as evidenced by: ew and interview on ailed to ensure that 1 control of the	of 1				
	Severity: 2 Scope: 3	3					
Y 870 SS=F	449.2742(1)(a)(1)(2)(Medication Administra	b)(c) 449.2742(1)(a)(1) ation		Y 870			

PRINTED: 05/01/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3522AGC 04/08/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4618 SPRUCE OAK** SPRUCE OAK RESIDENTIAL CARE FACILITY NORTH LAS VEGAS, NV 89031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 870 Continued From page 9 Y 870 NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. (2) Provides a written report of that review to the administrator of the facility: (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). This Regulation is not met as evidenced by: Based on record review and interview on 04/08/09, the facility failed to ensure that a medication profile review was performed by a physician, pharmacist or registered nurse at least

once every six months for 1 of 1 residents residing in the facility for longer than six months

(Resident #1).

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS3522AGC		B. WING		04/0	8/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	0.70	0/2000
SPRUCE (OAK RESIDENTIAL CAR	E FACILITY	4618 SPRU NORTH LAS	CE OAK S VEGAS, NV	89031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
Y 870	Continued From page	e 10		Y 870			
	Severity: 2 Scope: 3	3					
Y 895 SS=F	449.2744(1)(b)(1) Me	dication / MAR		Y 895			
	provides assistance to administration of med (b) A record of the me each resident. The re	lication shall maintain: edication administered					
	Based on record revie 04/08/09, the facility f medication administe (Resident #1).	ailed to record the type red for 1 of 1 residents	of				
	This was a repeat def State Licensure surve	ficiency from the 05/31/ ey.	/08				
	Severity: 2 Scope: 3	3					
Y 896 SS=F	449.2744(1)(b)(2) Me	dication / MAR		Y 896			
	provides assistance to administration of med (b) A record of the me each resident. The re	lication shall maintain: edication administered	to				

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time a resident refused or missed medication for

1 of 1 residents (Resident #1).

Severity: 2 Scope: 3

PRINTED: 05/01/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NVS3522AGC

NAME OF PROVIDER OR SUPPLIER

SPRUCE OAK RESIDENTIAL CARE FACILITY

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING
B. WING
COMPLETED

O4/08/2009

STREET ADDRESS, CITY, STATE, ZIP CODE
4618 SPRUCE OAK
NORTH LAS VEGAS, NV 89031

(X4) ID
PROVIDER'S PLAN OF CORRECTION (X5)

SPRUCE (OAK RESIDENTIAL CARE FACILITY	4618 SPRU NORTH LAS	CE OAK S VEGAS, NV	89031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 898	Continued From page 12		Y 898			
Y 898 SS=F	449.2744(1)(b)(4) Medication / MAR		Y 898			
	NAC 449.2744 1. The administrator of a residential facility to provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered each resident. The record must include: (4) Instructions for administering the medication to the resident that reflect the culorder or prescription of the resident's physical states.	to				
	This Regulation is not met as evidenced by Based on record review and interview on 04/08/09, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 1 residents (Resident #1).					
	Severity: 2 Scope: 3					
Y 936 SS=D	449.2749(1)(e) Resident file		Y 936			
	NAC 449.2749 1. A separate file must be maintained for earesident of a residential facility and retained least 5 years after he permanently leaves the facility. The file must be kept locked in a plathat is resistant to fire and is protected again unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related the resident, including without limitation: (e) Evidence of compliance with the provision of the service of	for at ne ace nst				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER NIVES 22 A C C		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
	ROVIDER OR SUPPLIER	NVS3522AGC ARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 4618 SPRUCE OAK NORTH LAS VEGAS, NV 89031					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F DR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Y 936	Continued From pa chapter 441A of NF adopted pursuant t	RS and the regulations		Y 936				
	Based on record re 04/08/09, the facilit	not met as evidenced by eview and interview on ty failed to ensure 1 of 1 with NAC 441A.380 reg g (Resident #1).						
	Severity: 2 Scope	e: 1						
Y 940 SS=C	Y 940 SS=C 449.2749(1)(g)(3) Resident file			Y 940				
	resident of a reside least 5 years after facility. The file muthat is resistant to funauthorized use. records, letters, as information and an the resident, including. An evaluation operform the activitied description of any aperform those activisuch an evaluation.	nust be maintained for eacential facility and retained the permanently leaves the state be kept locked in a plassifire and is protected again. The file must contain all sessments, medically other information related in the resident's ability to esto faily living and a brassistance he needs to writies. The facility shall put.	I for at ne					
	_	not met as evidenced by	<i>y</i> :					

PRINTED: 05/01/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3522AGC 04/08/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4618 SPRUCE OAK** SPRUCE OAK RESIDENTIAL CARE FACILITY NORTH LAS VEGAS, NV 89031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 940 Continued From page 14 Y 940 04/08/09, the facility failed to perform an annual evaluation of a resident's ability to perform the activities of daily living on 1 of 1 residents residing in the facility longer than a year (Resident #1). Severity: 1 Scope: 3